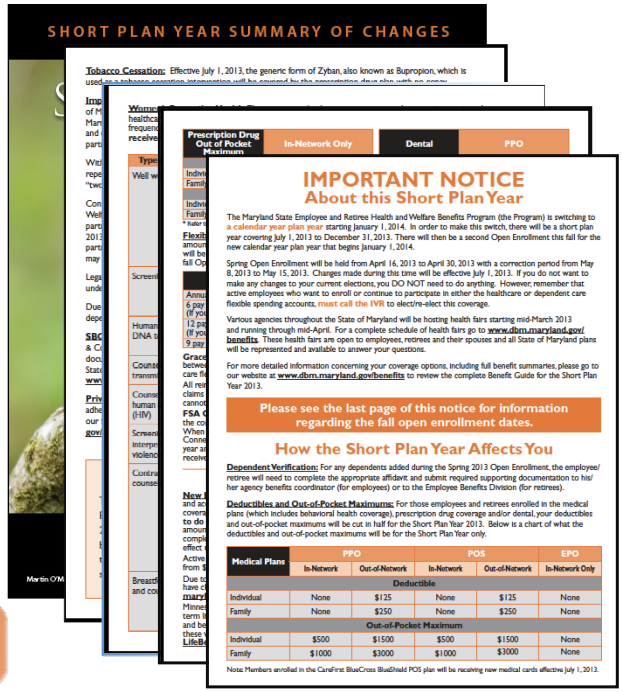
Short Plan Year 2013 Open Enrollment July 1, 2013 to December 31, 2013

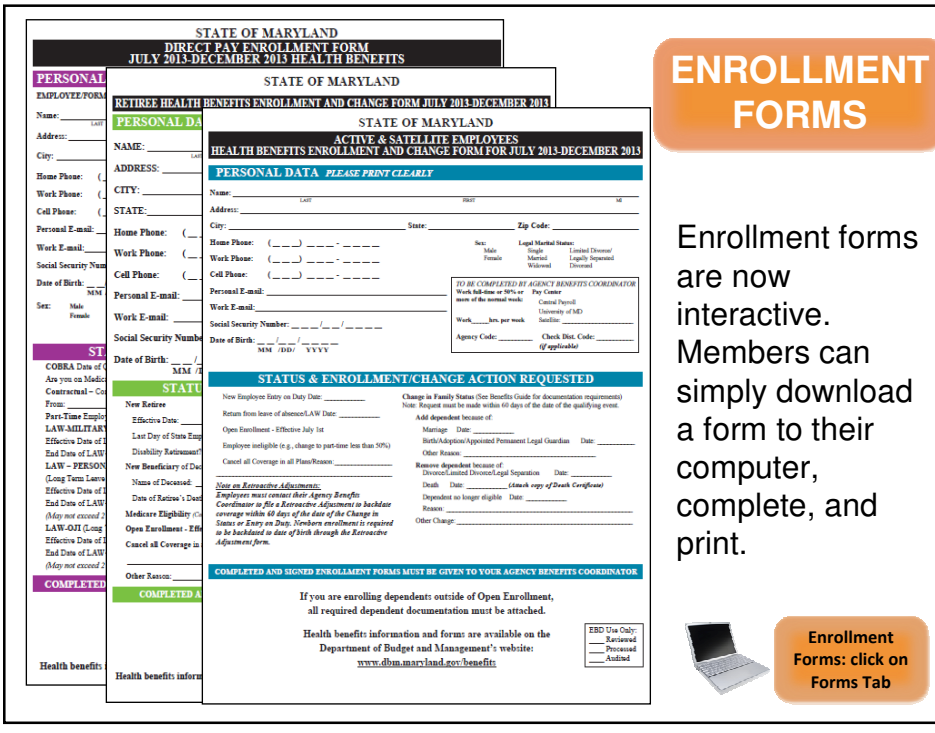
MARYLAND

DEPARTMENT OF BUDGET & MANAGEMENT
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201

The Open Enrollment Packet contains a Short Plan Year Summary of Changes instead of the full version of the Benefits Guide. The full version of the Benefits Guide is available online.



Click on the Benefits Guide Quick Link



ENROLLMENT FORMS

Enrollment forms are now interactive. Members can simply download a form to their computer, complete, and print.

Enrollment Forms: click on Forms Tab

IVR

- IVR Details and instructions on how to enroll are included in your OE packet
- IVR Number:
  - Baltimore area: 410-669-3893
  - Outside Baltimore area: 1-888-578-6434
- Employee's Login Information
  - ID: employee's social security number
  - PIN: month and day of employee's birthdate: mmdd

SUMMARY STATEMENTS

- Timing
  - You call IVR on Monday
  - EBD enters to system on Tuesday
  - New Summary Statement available on Wednesday
- Active employees: ask your ABC for your updated Summary Statement.
- Retirees and Direct Pay: EBD will mail you an updated version
- Is your address correct?
  - If you move, make sure you let us know!!

Personal Information Change form: click on Forms Tab

SUMMARY STATEMENTS

- Review your updated Summary Statement carefully!!
  - Spelling of names
  - Dates of Birth and Social Security Numbers
  - Correct tier of coverage
  - Assign the correct dependents to each plan
- "~" : this is a new dependent and documentation is needed.
  - Active: Gather the documentation and give to your ABC ASAP.
  - Retiree: EBD will mail you a letter when documentation is due

Dependent Documentation: click on Forms Tab

IMPORTANCE OF SOCIAL SECURITY

- We are required to report to CMS using social security numbers as they monitor for double coverage between our plan and state or federally sponsored welfare programs such as Medicaid or CHIP.
- Please provide if not shown on your summary statement.

DID YOU MISS A DEDUCTION?

(active State employees only)

- You'll receive a letter from EBD that you did not have some or all deductions taken from your pay.
- Speak with your ABC to determine if you owe the full amount (employee+state) or only the employee portion
- Voluntary: marriage, coverage backdated to some qualifying events, etc.
- Mandatory: birth of a child, missed deductions due to agency transfer, personal leave of absence

NO PAY LETTER – KEY WORDING

In certain situations, you may only be responsible for your portion of the premiums owed. **Please see your Agency Benefits Coordinator immediately to determine if you are eligible to receive the State subsidy for pay period ending (paydate).** If eligible, your Agency Benefits Coordinator will assist you in completing a Retroactive Adjustment to ensure your benefits are paid appropriately. The Retroactive Adjustment form and payment should be submitted to the address listed on the attached coupon page by (due date). If your agency determines that you are not eligible for a Retroactive Adjustment, you are responsible for the full amount (State subsidy and Employee Portion) due which must be received by (due date).

This is a debt owed to the State of Maryland. Failure to pay the total amount owed will result in referral of this debt to the State's Central Collection Unit, and in certain circumstances, your benefits may be cancelled. The Central Collection Unit will add a 17% collection fee to the amount you owe, and may report this debt to consumer credit reporting agencies. In the event your benefits are cancelled, you will be responsible for any claims incurred during this period. Please do not ignore this notice. If your coverage is cancelled for non-payment of this no-pay bill, your only opportunity to re-enroll in benefits will be during the next Open Enrollment period. Please be aware that you will receive additional no-pay notices for any pay period that insufficient wages prevent benefit premiums from being deducted.

HEALTH BENEFITS FOR RETIREES

- All active employees who leave state service are termed and receive a COBRA notice regardless of their reason for leaving.
- For timely processing, notify SRA three (3) months prior to retirement.
- SRA must approve and enroll the retiree in their system before we can enroll you in health benefits.
- Must complete a retiree health enrollment form.
- Retiree prescription drug benefits have a different out-of-pocket maximum than active employees.

Recommendation: Attend a pre-retirement seminar to better understand the retirement process and options.

WHAT TO CONSIDER WHEN SELECTING A MEDICAL PLAN…

- The Network of Physicians
- Your personal preference on the ability to see doctors who do not participate in the network
- Which services require pre-authorization
- Vision Care benefits
- What is important to YOU? (mobile applications, robust wellness services, certain discount programs, etc.)

*Benefits not specifically outlined in the SOM RFP may be covered differently by each carrier. Members should contact carriers or refer to the formal contract documents on the EBD website for detailed coverage information.

WHAT TO CONSIDER WHEN SELECTING A MEDICAL PLAN…

- Each carrier has their own network of available physicians and hospitals

	PPO	POS	EPO
Aetna	Not Available	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In-Network Doctors Only No International Network
CareFirst	National Network of Drs In- and Out-of-Network Choice International Network Available	Regional Network of Drs In- and Out-of-Network Choice No International Network	National Network of Drs In-Network Doctors Only International Network Available
United Healthcare	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In-Network Doctors Only No International Network

IMPORTANT DEFINITIONS

• PPO (Preferred Provider Organization) – A PPO is a health insurance plan that utilizes a network of physicians and facilities contracted by the insurance carrier to provide services within negotiated price boundaries. PPO members have the option to use physicians and facilities that are not part of the network, but their out of pocket costs will be significantly higher.

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible Individual Family	None None	$125 $250	None None	$125 $250	None None
Out-of-Pocket Coinsurance & Deductible Maximum Individual Family	$500 $1,000	$1,500 $3,000	$500 $1,000	$1,500 $3,000	None None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.				
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes

• POS (Point of Service) – A POS plan is like a hybrid between a PPO and an HMO. Members use a network of physicians and facilities to seek care, but also have the ability to see providers outside of the network.

• EPO (Exclusive Provider Organization) – An EPO is a type of managed care plan. The EPO uses a network of providers from which a member must choose. EPO members are restricted to using In-Network providers only.

IMPORTANT DEFINITIONS

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible Individual	None	$125	None	$125	None
Family	None	$250	None	$250	None
Out-of-Pocket Coinsurance & Deductible Maximum Individual	$500	$1,500	$500	$1,500	None
Family	$1,000	$3,000	$1,000	$3,000	None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.				
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes

• In-Network – Services provided by a Participating Provider or facility.

• Out-of-Network – Services received from providers outside of the plan's network. Such services are subject to up-front deductibles and coinsurance

• Deductible – The amount a member is required to pay before payment for services are paid for out-of-network treatment

• Out-of-Pocket Maximum (OOP)– This is the most a member will pay out of his or her pocket in coinsurance charges. The deductible is included in the OOP maximum. Copays are not included in the OOP maximum.

IMPORTANT DEFINITIONS

Primary Care Physician's Office Visit	$15 copay	70% of allowed benefit after deductible	$15 copay	70% of allowed benefit after deductible	$15 copay
Specialist Office Visit	$30 copay	70% of allowed benefit after deductible	$30 copay	70% of allowed benefit after deductible	$30 copay
Adult Physical Exams & associated lab work	100% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	Not covered	100% of allowed benefit
	One exam per plan year for all members and their dependents age 22 and older.				
Well Baby/Child Visits	100% of allowed benefit	70% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Inpatient Care/ Hospitalization (requires preauthorization)	90% of allowed benefit	70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission	90% of allowed benefit	70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission	90% of allowed benefit

• Copayment – The flat dollar amount a member pays at the time service is rendered. Copays vary by type of service.

• Coinsurance – Cost sharing between you and the plan for certain services. Expressed in terms of a percentage. Percentage shown is the insurance carrier's payment amount.

• Allowed Benefit – The maximum fee a health plan will pay for a covered service or treatment. Allowed benefit is determined by each health plan.

Doing the Math – Coinsurance

(example assumes individual coverage)

In-Network

$10,000 surgery
-but-
$8,000 is the allowed benefit
x 10% (patient coinsurance)
$800 (patient responsibility)

$1,000 is the Out-of-Pocket Max
- $800 patient responsibility 1st surgery
$200 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.
Your coinsurance responsibility (10%) will never exceed $1,000.

Out-of-Network

$10,000 surgery
-but-
$8,000 is the allowed benefit
- $250 deductible (patient responsibility)
$7,750
x 30% patient coinsurance
$2,325 patient responsibility (coinsurance)
+ $250 patient responsibility (deductible)
$ 2,575 total patient responsibility

$3,000 is the Out-of-Pocket Max
-$2,575 paid toward coinsurance & deductible
$425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

A Note About Out-of-Network Providers

Example From Previous Page

$10,000 surgery
-but-
$8,000 is the allowed benefit
- $250 deductible (patient responsibility)
$7,750
x 30% patient coinsurance
$2,325 patient responsibility (coinsurance)
+ $250 patient responsibility (deductible)
$ 2,575 total patient responsibility

$3,000 is the Out-of-Pocket Max
-$2,575 paid toward coinsurance & deductible
$ 425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

Beware of Balance Billing

- The $10,000 surgery had a maximum allowed benefit of $8,000.
- This leaves the provider with a difference in his charge and the amount he collects from the insurance company of $2,000.
- This provider can "Balance Bill" you for this difference.
- This would make total cost to you $4,575!!

We cannot stress enough how important it is to use In-Network providers in order to receive the best care at the lowest out-of-pocket cost!!

A Final Word About Out-of-Pocket Expenses

- Every July 1st, your deductible and out-of-pocket maximum resets to $0.
- You have to meet these costs every plan year.

- **You will never pay $10,000 out of your pocket toward your medical bills (unless you've used an out-of-network provider and are being balance billed)**

How does the Short Plan Year Affect You?

July 1, 2013 to December 31, 2013

COVERAGE LIMITS

- Deductibles and Out-of-Pocket Maximums will be cut in half for the Short Plan Year.
  - Applies to medical (PPO/POS), behavioral health, prescription drugs, and dental (DPPO).
- Dental plan yearly max is also cut in half
- Office Visit Limits <u>are not</u> being cut in half
  - Therapies, adult physical or well-child exam, glasses

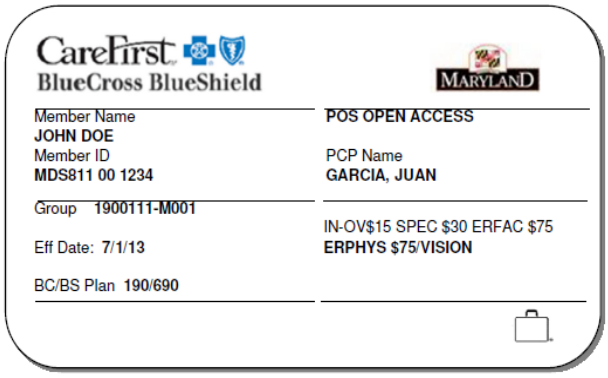
DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS CHARTS

Medical Plans	PPO		POS		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Deductible					
Individual	None	$125	None	$125	None
Family	None	$250	None	$250	None
Out-of-Pocket Maximum					
Individual	$500	$1500	$500	$1500	None
Family	$1000	$3000	$1000	$3000	None

Prescription Drug Out of Pocket Maximum	In-Network Only
Active Employees	
Individual	$500
Family	$750
Retirees	
Individual	$750
Family	$1000

Dental	PPO
Deductible (applies to Class II & Class III Services)	
Individual	$25
Family	$75
Plan Year Maximum	
Per Participant	$750

CAREFIRST POS PLAN



Members enrolled in the CareFirst POS plan will receive new cards effective July 1, 2013.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Changes in the minimum and maximum election amounts for the short plan year.

Pay Periods	Healthcare FSA		Dependent Care FSA	
	Minimum	Maximum	Minimum	Maximum
Annually	$60.00	$1,250.00	$60.00	$2,500.00
6 pay period deductions (If you are paid monthly)	$10.00	$208.33	$10.00	$416.66
12 pay period deductions (If you are paid bi-weekly)	$5.00	$104.16	$5.00	$208.33
9 pay faculty scheduled deductions	$6.66	$138.88	$6.66	$277.77

FLEXIBLE SPENDING ACCOUNTS (FSA) DEADLINES

- Healthcare : July 1, 2013 to March 15, 2014.
- Dependent Day Care : July 1, 2013 to Dec 31, 2013.
- All claim reimbursement requests must be submitted to CYC by April 15, 2014.
- Funds remaining in your account(s) after April 15th are forfeited!
- You cannot request reimbursement for claims incurred after your last day worked.

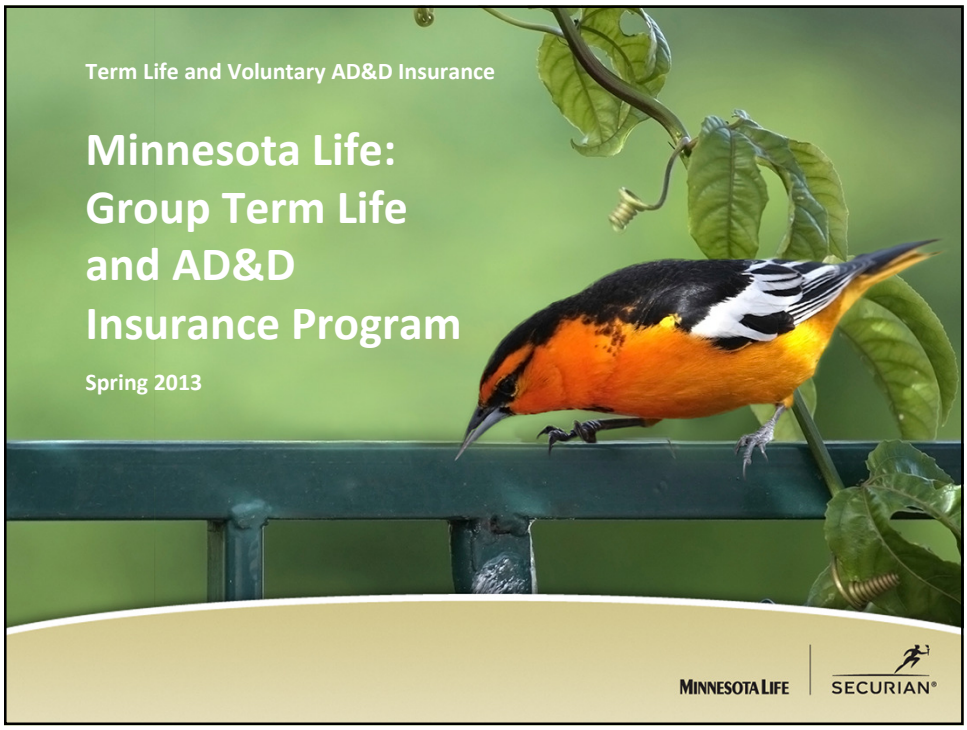
FLEXIBLE SPENDING ACCOUNTS (FSA) PAYMENT CARD

- Card expires 3 years from the month of issue.
- CYC automatically sends a new card.

This is of particular note for 7/1/13. If you enrolled when CYC was first effective on 7/1/10, you will be receiving a new debit card.

WHAT'S NEW AS OF JULY 1, 2013

- New Life and AD&D Carrier
- Women's Preventive Health Enhancements
- Tobacco Cessation
- Domestic Partner Coverage
- Summary of Benefits & Coverage



Plan design

- No coverage changes to the plan design:
  - Employee Life
  - Spouse Term Life
  - Child Term Life
  - Accidental Death & Dismemberment
- Change in rates, see rate sheets for details
- Existing coverage transfers automatically
- No action required for transition
- Access to LifeSuite Services

Employee Term Life

Class 1

$10,000 increments, up to $300,000

Class 2

$10,000 increments, up to $500,000

- Class 1: All active employees that are not classified as class 2 employee
- Class 2: Active employees who fly in a helicopter, scuba dive, or are involved in other high risk services in the course of their employment with the State
- Employees must elect Term Life in order to elect coverage for spouse and/or child(ren)
- Guaranteed coverage (up to $50,000 maximum) available at initial eligibility, annual enrollment, and family status changes

Term Life for Dependents

Spouse

$5,000 increments, up to $150,000

Child

$5,000 increments, up to $150,000

- Dependent coverage cannot exceed 50% of member's Life amount
- No dual coverage
- Children are eligible from live birth up to age 26
- Guaranteed coverage (up to $25,000 maximum) available at initial eligibility, annual enrollment, and family status changes

Voluntary AD&D

Employee Plan

- $100,000
- $200,000
- $300,000

Family Plan

- Spouse (w/children): 55%
- Spouse only: 65%
- Child (w/spouse): 15%
- Child only: 25%

2013 Special Opportunity

Term Life	Spouse Life	Child Life
• $50,000 guaranteed coverage maximum	• $25,000 guaranteed coverage maximum	• $25,000 guaranteed coverage maximum

- April 16 – April 30, 2013
- Available for current participants and members enrolling for the first time.
- Coverage amounts over the guaranteed maximums and/or elected after April 30, 2013 will require EOI.

Medical Underwriting

- aka EOI or Evidence of Insurability
- Employees will be contacted directly by Minnesota Life if needed
- Online process: www.LifeBenefits.com/Maryland
- Approval or denial confirmation to employee and Employee Benefits Division

Continuing Coverage

Portability

If an employee is no longer eligible for coverage as an active employee, coverage may be continued, and premiums paid directly to Minnesota Life.

Conversion

If an employee is no longer eligible for coverage as an active employee, OR ported coverage has terminated, coverage may be converted to an individual life policy.

- Contact Minnesota Life for details

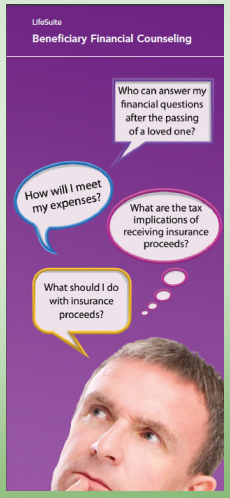
LifeSuite Services

1. Beneficiary Financial Counseling
2. Travel Assistance
3. Legal Services
4. Legacy Planning Services

- Certain terms and conditions may apply

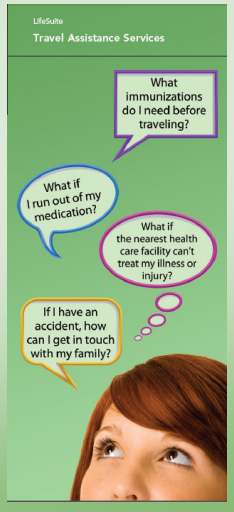
Beneficiary Financial Counseling

- Provider: PricewaterhouseCoopers LLP
- Invitation included in claim check
- Complimentary financial counseling
- No sales



Travel Assistance

- Provider: Global Rescue
- 24-hour emergency travel service
- Travel for business or pleasure
- Dependents traveling without employee (including college)
- 100 miles or more away from home
- Locate physician, dentist, western-medicine facilities, etc.
- Secure language interpreter, the return of mortal remains, etc.

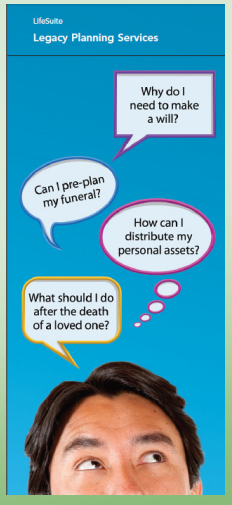


Legal Services

- Provider: Ceridian
- Online library of legal resources
- Develop simple wills, trusts, power-of-attorney
- National network of 22,000 attorneys
- 30-minute free consultation
- 25% discount for charged services

Legacy Planning Services

- www.LegacyPlanningServices.com
- Legacy planning
- Final arrangements
- Easy access to resources



Resources

- Online Information
  - www.dbm.maryland.gov/benefits
  - www.LifeBenefits.com/Maryland
- Printed Publications
  - State of Maryland Benefits Guide
  - Various fliers for health fairs (i.e. the importance of selecting a beneficiary)
- Phone
  - Minnesota Life: 1-866-883-3514

Questions?

Thank you for your time!

Do you have any questions?

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life to the State of Maryland. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. Products offered under policy form series numbers 13-31481 and 13-31487.

Services provided by Ceridian, Global Rescue LLC, and PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services.

Minnesota Life Insurance Company
A Securian Company

Group Insurance
www.LifeBenefits.com

400 Robert Street North, St. Paul, MN 55101-2098
F78524-1 1-2013
A00635-0213

WOMEN'S PREVENTIVE HEALTH

- Enhancements are due to healthcare reform
- Services are provided at no cost to our members as long as they are received from an in-network provider.

WELL WOMAN VISITS

- Coverage
  - Age and developmentally appropriate preventive services
  - Includes preconception counseling, prenatal care (routine obstetrical office visits, recommended immunizations, tobacco cessations counseling), preventive mammograms, and immunizations.
- Frequency
  - As necessary based on a woman's health status, needs, and risk factors.

COUNSELING & SCREENINGS

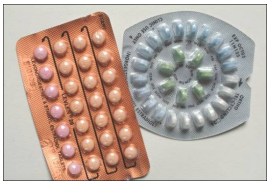
- Screening for gestational diabetes
  - during 24 to 26 weeks of pregnancy and at first prenatal visit for high risk pregnant women
- HPV DNA testing
  - once every 3 years after age 30
- Counseling and screening for STI, HIV and interpersonal and domestic violence

CONTRACEPTION METHODS

COVERED WITH ZERO COST SHARE TO THE MEMBER

PRESCRIPTION DRUG PLAN:

- Generic Oral Contraceptives
- Diaphragm
- Levonorgestrel (Generic Plan B)



MEDICAL PLAN:

- IUDs
- Tubal Ligation

BREASTFEEDING SUPPORT, SUPPLIES & COUNSELING

- Covers the cost for certain breastfeeding equipment.
- Equipment must be obtained by the member through their medical carrier's durable medical equipment partner(s).
- Does not cover breastfeeding supplies such as tubing, pads, or containers.

TOBACCO CESSATION

-already available-

- Counseling
- Zero cost under medical program

-new-

- Generic form of Zyban (Bupropion)
- Available through Express Scripts Rx program
- Zero dollar copayment

MD Civil Marriage Protection Act

- Effective January 1, 2013
- Marriage legal in MD for both opposite and same sex couples
- Imputed Income and post-tax deductions for same sex couples are still required due to federal regulation (DOMA)

SAME SEX DOMESTIC PARTNERS

- Currently enrolled same sex domestic partners and their dependent children are able to stay on coverage through December 31, 2013.
- No new domestic partner enrollments after June 30, 2013.
- On January 1, 2014, our plans will no longer cover domestic partners.
- In order to continue coverage beyond December 31, 2013, couple must be legally married. Will need updated affidavit and a copy of marriage certificate.

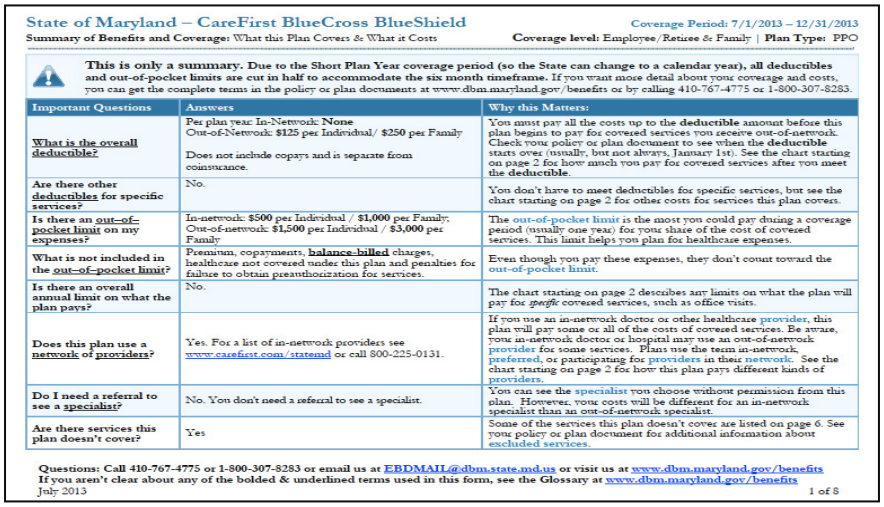
Affidavit: click on Forms Tab

SUMMARY OF BENEFITS & COVERAGE (SBC)

- Healthcare reform requirement.
- Plan is required to provide a customized SBC for each plan type and coverage level.
- Helps members to compare plan options.
- Are available on EBD website.

Click Summary of Benefits & Coverage tab

SBC – Page 1



State of Maryland – CareFirst BlueCross BlueShield

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 – 12/31/2013

Coverage level: Employee/Retiree & Family | **Plan Type:** PPO

This is only a summary. Due to the Short Plan Year coverage period (so the State can change to a calendar year), all deductibles and out-of-pocket limits are cut in half to accommodate the six month timeframe. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.dbm.maryland.gov/benefits or by calling 410-767-4775 or 1-800-307-8283.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per plan year: In-Network: **None** Out-of-Network: **$125** per Individual/ **$250** per Family Does not include copays and is separate from coinsurance.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you receive out-of-network. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	In-network: **$500** per Individual / **$1,000** per Family; Out-of-network: **$1,500** per Individual / **$3,000** per Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
What is not included in the **out–of–pocket limit**?	Premium, copayments, **balance-billed** charges, healthcare not covered under this plan and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of in-network providers see www.carefirst.com/statemd or call 800-225-0131.	If you use an in-network doctor or other healthcare provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. However, your costs will be different for an in-network specialist than an out-of-network specialist.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
If you aren't clear about any of the bolded & underlined terms used in this form, see the Glossary at www.dbm.maryland.gov/benefits

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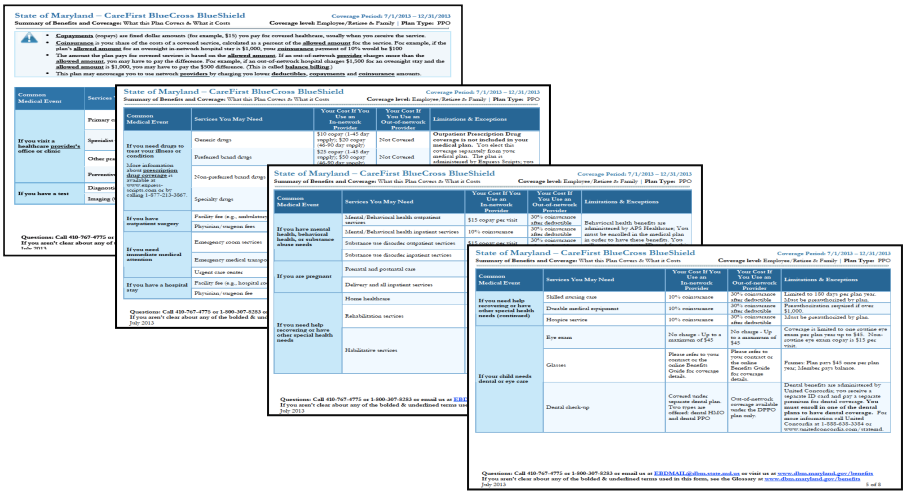
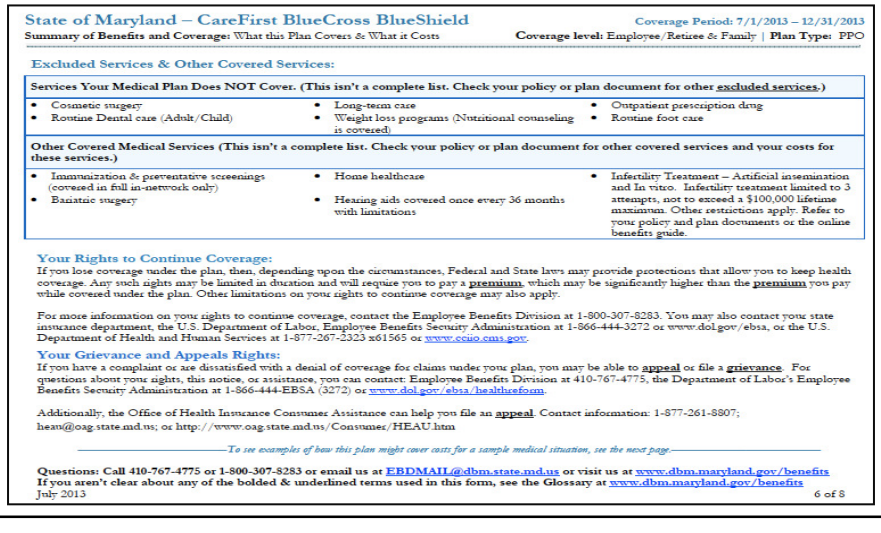
SBC - Pages 2-5



SBC – Page 6



State of Maryland – CareFirst BlueCross BlueShield

Coverage Period: 7/1/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage level: Employee/Retiree & Family | Plan Type: PPO

Excluded Services & Other Covered Services:

Services Your Medical Plan Does NOT Cover. (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Routine Dental care (Adult/Child)
- Long-term care
- Weight loss programs (Nutritional counseling is covered)
- Outpatient prescription drug
- Routine foot care

Other Covered Medical Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Immunization & preventative screenings (covered in full in-network only)
- Bariatric surgery
- Home healthcare
- Hearing aids covered once every 36 months with limitations
- Infertility Treatment – Artificial insemination and In vitro. Infertility treatment limited to 3 attempts, not to exceed a $100,000 lifetime maximum. Other restrictions apply. Refer to your policy and plan documents or the online benefits guide.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Employee Benefits Division at 1-800-307-8283. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Employee Benefits Division at 410-767-4775, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, the Office of Health Insurance Consumer Assistance can help you file an **appeal**. Contact information: 1-877-261-8807; heau@oag.state.md.us; or http://www.oag.state.md.us/Consumer/HEAU.htm

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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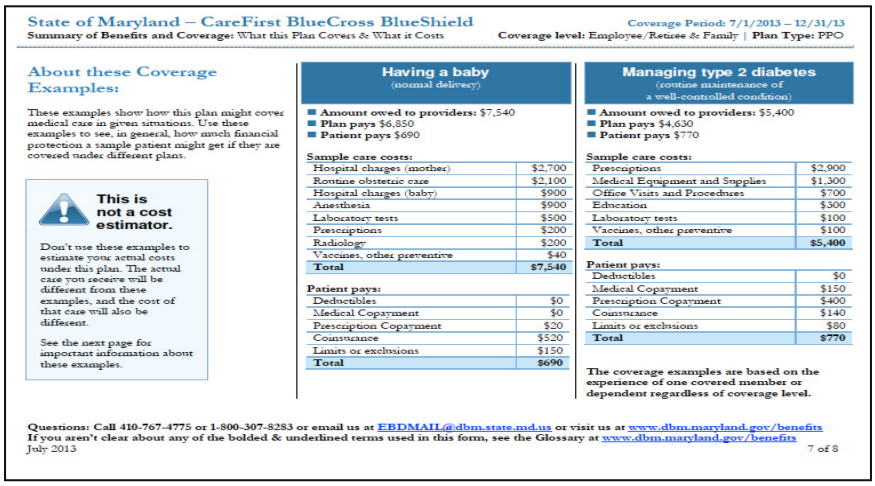

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,850
- **Patient pays** $690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Medical Copayment	$0
Prescription Copayment	$20
Coinsurance	$520
Limits or exclusions	$150
Total	**$690**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Medical Copayment	$150
Prescription Copayment	$400
Coinsurance	$140
Limits or exclusions	$80
Total	**$770**

The coverage examples are based on the experience of one covered member or dependent regardless of coverage level.

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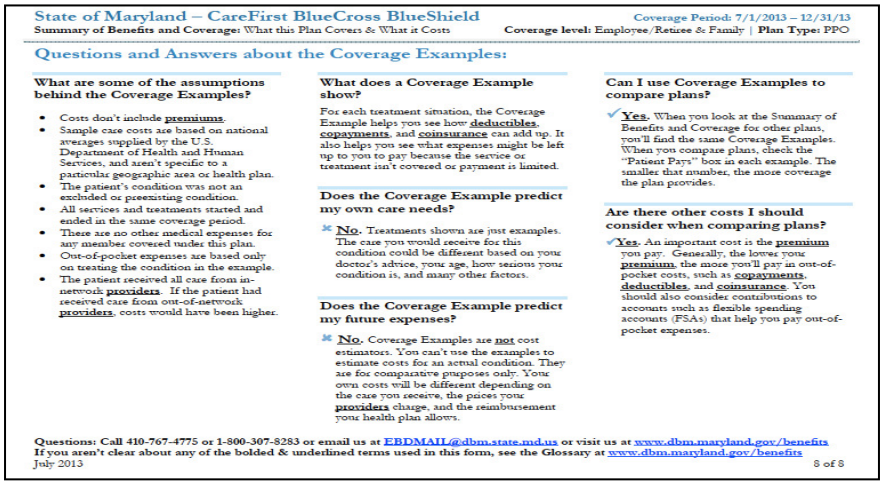


Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as flexible spending accounts (FSAs) that help you pay out-of-pocket expenses.

PPACA INDIVIDUAL MANDATE

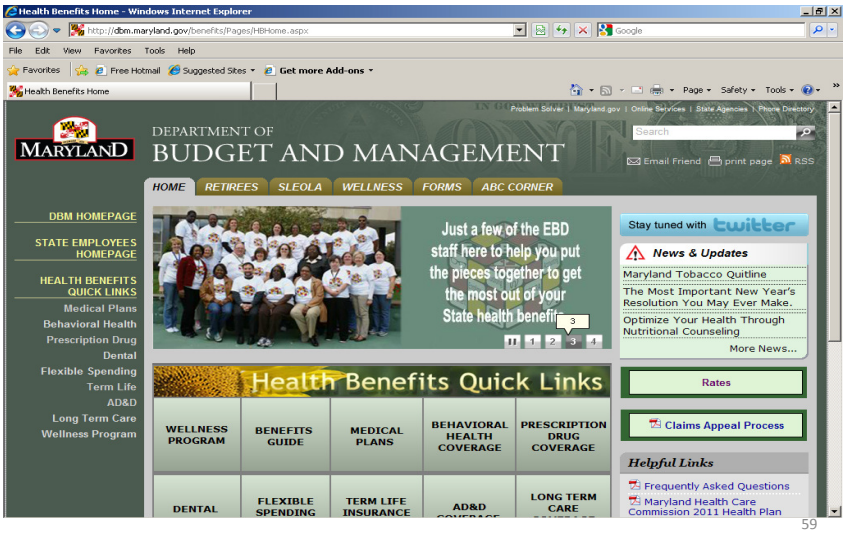
- Part of healthcare reform (PPACA §§ 1501, 1502 and 10106).
- As of January 1, 2014, individuals are required to maintain minimum essential coverage each month or pay a penalty.
- More to come from EBD during Fall OE.

FALL OE & DVA

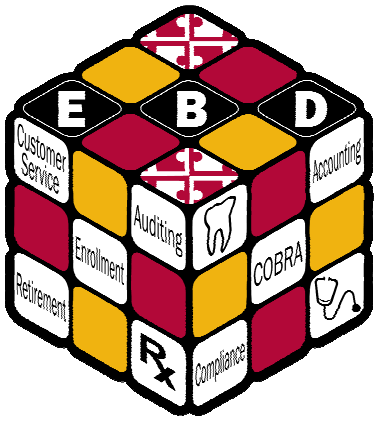
- Health Fairs for Employees will be in September 2013
- OE will occur in October 2013

DBM-EBD WEBSITE

www.dbm.maryland.gov/benefits



Thank You For Participating!



Local: 410-767-4775
Toll-Free: 1-800-30-STATE

PUTTING the PIECES TOGETHER